

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Dist. No. 02207 350

1. PLACE OF DEATH:

County Worcester
 City or town Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Pocomoke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6th St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Gordon George Barnes

3. (b) Social Security Number

212-18-6931

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mary M. Barnes
 6. (c) If alive, give age 35 years
 7. Birth date of deceased (mo., day, yr.) November 25, 1905
 8. AGE: Years 39 Months 2 Days 10 hrs. min.

8. Birthplace Coleman, N. C.
 (Town, county, and state)
 10. Usual occupation Game warden

11. Industry or business

12. Name G. B. Barnes
 13. Birthplace N. C.
 14. Maiden name Lena Edwards
 15. Birthplace N. C.

16. Informant Mrs. Mary M. Barnes
 Address Pocomoke City, Md.

17. Burial Date thereof Feb 9, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Halls Hill
 Location Pocomoke City

18. Funeral director Margarette N. Watson
 Address Pocomoke City, Md.

19. Feb. 9, 1945 Anne E. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5th, 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1945 to 1945
 and that I last saw him alive on 1945

Immediate cause of death Lacerations of Brain
 Due to gun shot wounds
 Due to gun shot wounds
 Other conditions gun shot wounds
 (Include pregnancy within 3 months of death)

Major findings of operations gun shot wounds
 Autopsy results gun shot wounds
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide suicide Date of Feb 5th 1945
 Where did injury occur? Pocomoke City, Worcester Co., Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) grocery store
 Means of injury shot by hot gun Injured at work? yes

23. SIGNATURE N. E. Santorius M.D.
 Address Pocomoke City, Md. Date signed 7/7/45

RECEIVED

MAR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Pocomoke city
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester
 City or town Pocomoke city
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Laurel
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3.(a) FULL NAME

John William Bevans Jr.

3.(b) Social Security Number

✓

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white widowed

6.(b) Name of husband or wife Annie Bevans6.(c) If alive, give age ✓ years7. Birth date of deceased (mo., day, yr.) March 15, 1875

8. AGE: Years 69 Months 11 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Withams, Accomac, Va
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John W. Bevans Jr.13. Birthplace Virginia14. Maiden name Unknown

15. Birthplace

16. Informant Archie BevansAddress Pocomoke city, md.17. Burial Date thereof Feb. 28, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Halls Hill Baptist CmeLocation Pocomoke city, md.18. Funeral director Margarette H. WatsonAddress Pocomoke city, md.19. Feb 27 19 45 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 19 45 at 10 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 19 45 to Feb 25 19 45and that I last saw him alive on Feb 25 19 45Immediate cause of death Acute myocardial infarctionDue to ArteriosclerosisDue to 3 day

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. MasonAddress Pocomoke cityDate signed 2/26-45

RECEIVED
MAR 6 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 312

CERTIFICATE OF DEATH

Reg. Dist. No. 356

1. PLACE OF DEATH:

County Worcester
 City or town Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 93 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Cyrus W. Davis

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

8. (b) Name of husband or wife Charlotte Dime Davis

7. Birth date of deceased (mo., day, yr.) December 9, 1851 8. (c) If alive, give age _____ years

8. AGE: Years 93 Months 2 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Berlin, Wor. Co. Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Thomas C. Davis
 13. Birthplace Berlin, Maryland

MOTHER 14. Maiden name Martha Hudson
 15. Birthplace Berlin, Md

16. Informant Mrs. Eva Phillips
 Address Berlin, Md.

17. Burial Date thereof 2/7/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen
 Location Berlin, Md

18. Funeral director Franklin B. Deil
 Address Salisbury, Md

19. 2-7 45 Helen F. Hayward
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Feb 5 1945
 and that I last saw him alive on Feb 4 1945

Immediate cause of death Hypostatic
pneumonia
 Due to hypertension
 Due to chronic Dvt
Nephritis
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Clifford E. Schott M. D. or other _____
Berlin Md
 Address _____ Date signed _____

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECORDED
MAR 2 1945
BUREAU A.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 710

CERTIFICATE OF DEATH

Reg. Dist. No. 02210 355

1. PLACE OF DEATH: County <u>Worcester</u> City or town <u>Berlin</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>60 yrs</u> Hospital, institution, or street address where death occurred: <u>✓</u> How long in hospital or institution? <u>✓</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Worcester</u> City or town <u>Berlin</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>R.F.D.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>✓</u>			
3. (a) FULL NAME <u>Maria E. Donoway</u>				3. (b) Social Security Number <u>—</u>			
4. Sex <u>Female</u> 5. Color or race <u>White</u> 6. (a) Single, married, widowed, or divorced <u>Widow</u>				MEDICAL CERTIFICATION			
6. (b) Name of husband or wife <u>John S. Donoway</u>				20. DATE OF DEATH <u>2-12-45</u> 19 <u>45</u> at <u>5 P</u> M			
7. Birth date of deceased (mo., day, yr.) <u>July 7, 1859</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1-1-45</u> 19 <u>45</u> to <u>2-2-45</u> 19 <u>45</u>			
8. AGE: Years <u>85</u> Months <u>7</u> Days <u>15</u> If less than one day <u>—</u> hrs. <u>—</u> min.				and that I last saw him alive on <u>2-2-45</u> 19 <u>45</u>			
9. Birthplace <u>Whaleville, Md.</u> (Town, county, and state)				Immediate cause of death <u>Coronary occlusion</u>			
10. Usual occupation <u>Housewife</u>				Due to <u>6 hours</u>			
11. Industry or business <u>Housewife</u>				Due to			
12. Name <u>Edw. Adkins</u>				Other conditions <u>Hypertension</u>			
13. Birthplace <u>Md.</u>				Other conditions <u>atherosclerosis</u> (Include pregnancy within 3 months of death)			
14. Maiden name <u>Mary Elizabeth Brittingham</u>				Major findings at operations			
15. Birthplace <u>Md.</u>				Date of op.			
16. Informant <u>Miss Ethel Donoway</u>				Autopsy results			
Address <u>Berlin, Md. R.F.D.</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial <u>Burial</u> Date thereof <u>Feb 14, 1945</u> (Burial, cremation, or removal, Which?) (month) (day) (year)				22. VIOLENCE: If death was due to external causes, fill in the following;			
Cemetery or crematory <u>Evergreen</u>				Accident, suicide, or homicide			
Location <u>Berlin, Md.</u>				Where did injury occur? (City or town) (County) (State)			
18. Funeral director <u>M. Frank Watson</u>				Injured at home, farm, industry, public place (where?)			
Address <u>Silkyville, Del.</u>				Means of injury Injured at work?			
19. 2-14 1945 <u>Delia F. Hayward</u> (Date rec'd by registrar) Registrar				23. SIGNATURE <u>Frank A. Lewis M.D.</u> M. D. or other Address <u>Wallerde Md</u> Date signed <u>2-13-45</u>			

RECEIVED
MAR 2 1965
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 151a

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH: Worcester
County Snow Hill
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution or street address where death occurred: RD #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD #2
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME Gilbert Hartman Fooker
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Annie Ellen Fooker

6. (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) April 12, 1869

8. AGE: Years 75 Months 10 Days 7 If less than one day hrs. min.

9. Birthplace Worcester Co. Md.
(Town, county, and state)

10. Usual occupation Retiree

11. Industry or business Farmer

12. Name Benjamin Fooker

13. Birthplace Worcester Co. Md.

14. Maiden name Mary Ellen Causey

15. Birthplace Worcester Co. Md.

16. Informant Mrs. Nora J. Purdue

Address RD #2, Snow Hill Md.

17. Burial Date thereof Feb 21-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fooker Cemetery

Location Worcester Co. on Salaty & Snow Hill Rd

18. Funeral director Holman & G. Walter R. Holman

Address Salisbury Maryland.

19. 2/20/45 19 45 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/14/45 to 2/19/45
and that I last saw him alive on 2/18/45

Immediate cause of death: Pneumonia
DURATION 1 wk

Due to: Hypertension Chronic
Degenerative

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul R. Smith M.D.
Address Salisbury Date signed 2/20/45

RECEIVED

MAR 5 1945

BUREAU

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02212

1. PLACE OF DEATH

County

Village or City

No.

Registration Dist. No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than
1 day, hrs.
of min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

(State or country)

FATHER

13. NAME

14. BIRTHPLACE (city or town)

(State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town)

(State or country)

17. INFORMANT

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDOERTAKER

(Address)

20. FILED

19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

(Month)

(Day)

19

(Year)

22.

I HEREBY CERTIFY That I attended deceased from

I last saw him alive on

to have occurred on the date stated above, at

The PRINCIPAL CAUSE OF DEATH and related causes of Importance
were as follows:

Date of onset

Other Contributory Causes of Importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic" but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	Date of onset 1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
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Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset 1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

02213

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cedar Street, Extended
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Ella M. Lambertson

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
<u>Female</u>	<u>White</u>	<u>Married</u>	
6. (b) Name of husband or wife		6. (c) If alive, give age	
<u>Walton Lamberston</u>		<u>55</u> years	
7. Birth date of deceased (mo., day, yr.) <u>January 10, 1896</u>			
8. AGE:	Years	Months	Days
	<u>49</u>	<u>1</u>	<u>12</u>
	If less than one day _____ hrs. _____ min.		

9. Birthplace Gloucester County, Virginia
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

MOTHER	12. Name	<u>William P. Brushwood</u>
	13. Birthplace	<u>Gloucester County, Virginia</u>
	14. Maiden name	<u>Mary Alice Willett</u>
FATHER	15. Birthplace	<u>Gloucester County, Virginia</u>

16. Informant Walton Lambertson

Address Cedar St., Pocomoke City, Md.

17. Burial Date thereof Feb. 26, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baptist Cemetery

Location Pocomoke City, Maryland

18. Funeral director H. Harvey Bradshaw

Address Pocomoke City, Maryland

19. Feb. 26, 1945 Anne E. Hite
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-45 at 12:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw her alive on 2/21 1945

Immediate cause of death Coronary thrombosis

Due to old fall

Due to Epileptic fit

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? Pocomoke City, Worcester, Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Self inflicted Injured at work? yes

23. SIGNATURE J. E. Hartman, M.D.
 Address Pocomoke City, Md. Date signed 2/23/45

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED

MAR 6 1945

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-12

CERTIFICATE OF DEATH

02214

Reg. Dist. No. 350

1. PLACE OF DEATH:

County... Worcester
 City or town... RURAL, Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
75 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Worcester
 City or town... RURAL, Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. # RFD 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charles Merrill

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
Male	Colored	Married	

8. (b) Name of husband or wife... Sarah Merrill
 8. (c) If alive, give age 75 years
 7. Birth date of deceased (mo., day, yr.) April 27, 1870
 8. AGE: Years Months Days If less than one day
 74 9 14 hrs. min.

9. Birthplace... Pocomoke, RURAL-Worcester-Md.
 (Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business... Truck Farms

12. Name... George Merrill

13. Birthplace... RURAL, Pocomoke City, Md.

14. Maiden name... Sarah Quinn

15. Birthplace... Worcester County, Md.

16. Informant... Mrs. Sarah Merrill

Address... Pocomoke City, Md. RFD # 2

17. Burial Date thereof... Feb. 14, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... St. James Cemetery

Location... Pocomoke City, Md. RFD # 2

18. Funeral director... H. Harvey Bradshaw

Address... Pocomoke City, Md.

19. Feb. 14 1945 Anne E. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 14 1945 at 11:25 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1944 to Feb 14 1945

and that I last saw him alive on Feb 15 1945

Immediate cause of death... Infected

Heart

Due to... Chronic Degenerative

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. E. Pritchard

M. D. or other

Address... Green Church

Date signed... 7-12-45

HEALTH DEPARTMENT OF MASSACHUSETTS

CERTIFICATE OF DEATH

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH OUTFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

02215

Reg. Dist. No. 351

1. PLACE OF DEATH:
 County..... Worcester
 City or town..... Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 81 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Worcester
 City or town..... Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 124 Martin St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 William Samuel Williams

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... Ellen Bell Williams
 7. Birth date of deceased (mo., day, yr.)..... Mo + day unknown 1864 6.(c) If alive, give age..... years
 8. AGE: Years..... 81 Months..... ? Days..... ? If less than one day..... hrs. min.

9. Birthplace..... Snow Hill-Worcester-Maryland
 (Town, county, and state)

10. Usual occupation..... Funeral Director

11. Industry or business

12. Name..... Samuel Williams
 13. Birthplace..... Snow Hill (vicinity) Md
 14. Maiden name..... Leah Boyer
 15. Birthplace..... Worcester County, Md

16. Informant..... Roger Williams
 Address..... 124 Martin St., Snow Hill, Md

17. Burial..... Date thereof..... Feb 9, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Methodist Cemetery
 Location..... Snow Hill, Md

18. Funeral director..... H. Harven Bradshaw
 Address..... Pocomoke City, Md

19. 2/9/45 1945 L. L. Day Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 5, 1945 at 6:15 A.M.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from
 February 2, 1945 to Feb. 5, 1945
 and that I last saw him alive on February 2, 1945

Immediate cause of death..... Pulmonary
 DURATION..... 6 days

Due to.....

Due to.....

Other conditions..... Permanent dislocation
 Left hip
 (Include pregnancy within 3 months of death) many years

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert L. La Mar, M.D.
 M. D. or other

Address..... Snow Hill Date signed..... 2/5/45

RECEIVED

RECEIVED

RECEIVED

MAR 5 1945

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1376

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary C. Wilson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

James Wilson

7. Birth date of deceased (mo., day, yr.)

unknown 1873

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

about 72

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name Lease Brice13. Birthplace Maryland14. Maiden name Ann Cornell15. Birthplace Maryland16. Informant George JohnsonAddress Berlin, Md.17. Buried
(Burial, cremation, or removal. Which?)

Date thereof

2/12/45
(month) (day) (year)

Cemetery or crematory

GERMANTOWNLocation BERLIN, MD.18. Funeral director Franklin B. HillAddress Salisbury, Md.19. 2-12 45 Helin F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1945 19____ at 10:30 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 1944 to Feb. 7, 1945 and that I last saw him alive on Feb. 7, 1945 19____

Immediate cause of death

DURATION

General Anemia 3 mos.

Due to

Congestive Heart Failuremyocarditis yearOther conditions Chronic Nephritis year
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury _____ Injured at work?

Signature G. L. Semblly MDAddress Salisbury, Md. Date signed 2/12/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

JOHN CHAMBERLAIN

CERTIFICATE OF DEATH

JOHN CHAMBERLAIN

RECEIVED
MAR 2 1945
BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (No)

CERTIFICATE OF DEATH

Reg. Dist. No. 955

1. PLACE OF DEATH:

County WorcesterCity or town Berlin R.T.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin R.T.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Blanche Wyatt

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white _____

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) April 20, 19438. AGE: Years Months Days If less than one day
1 10 16 _____ hrs. _____ min.9. Birthplace Berlin Worcester Co. Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Herman H. Wyatt
13. Birthplace Berlin Md.14. Maiden name Mollie M. Mariner
15. Birthplace Silbyville Del.18. Informant Mr. George Wyatt
Address Berlin Md. R.T.D.17. Burial Date thereof 2/8/45
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory New HopeLocation Willard Md. R.T.D.18. Funeral director Franklin B. DeilAddress Salisbury Md.19. 2-8- 1945 Helen J. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 19 45 at 3:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____

Dinner almost completely severedDue to House burned down suicide

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. H. Thucoll M.D.

M. D. or other _____

Address Berlin Md. Date signed _____

CERTIFICATE OF DEATH

RECORDED
MAR 2 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

02218

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin, R.I.D.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin, R.I.D.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Denny W. Wyatt

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

S

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 12, 1939

8. AGE: Years Months Days If less than one day

5 7 24 hrs. min.9. Birthplace Berlin, Wor. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name George H. Wyatt13. Birthplace Maryland14. Maiden name Millie M. Mariner15. Birthplace Delaware16. Informant Mr. George H. WyattAddress Berlin, Md. R. 2 D.17. Burial Date thereof 2/8/45
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory New HopeLocation near Willard, Md. R. 2 D.18. Funeral director Franklin B. HillAddress Salisbury, Md.19. 2-8- 19 45 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 19 45 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death Burned almost completelyDue to House burned down. Ciga.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature L. McCall M.D.Address Berlin, Md. Date signed 2-7-45

CERTIFICATE OF DEATH

RECORDED
MAR 2 1946
BUREAU A.B.